COMPLAINT 3 (CHECK ONLY 1 there is additional space for more complaints on next page)

☐Neck Pain ☐Headache ☐Migraine ☐ Upper/Mid Back Pain ☐Low Back Pain
☐Shoulder Pain ☐Knee Pain ☐Jaw Pain ☐Hip Pain
Pain or problem started on _____

Do you notice the pain during a certain time of day? ☐Morning ☐Afternoon ☐Evening ☐Night

Do you know what caused the problem?
☐Fall ☐Trauma ☐Accident ☐ Bending ☐Exercise ☐Housework ☐Lifting
☐Running ☐Working ☐Sports injury ☐Turning ☐Twisting ☐Sleeping wrong ☐Standing

Frequency: How often do you feel the pain?

☐ Constant ☐ Semi Constant ☐Comes and Goes ☐Other _____

Duration: How long does the pain last when you feel symptoms?

☐Constant ☐Frequent ☐Intermittent ☐Occasional ☐Infrequent ☐other _____

Onset: You have had this symptom over the past: Days, weeks, months or years?

☐Childhood ☐Adulthood ☐Year of_____ ☐Month of_____ ☐Exactly this date_____

Has the condition gotten better, worse or stayed the same since its onset?

☐Better ☐Worse ☐Stayed the Same

Quality: How would you describe the pain?

☐ Aching ☐Burning ☐Cramping ☐Deep ☐ Dull ☐Numb ☐Radiating ☐Sharp
☐Shooting ☐Sore ☐Stabbing ☐Stiff ☐Swelling ☐Tight ☐Tingling ☐Throbbing

Aggravating Factors: What makes the problem worse?

☐Nothing ☐Most Movements ☐Bending ☐Carrying things ☐Coughing ☐Driving
☐Eating ☐Exercise ☐down stairs ☐Heat ☐Housework ☐Ice
☐ Jogging ☐Lifting ☐Lying down ☐Massage ☐Pulling ☐Pushing
☐Running ☐Sitting ☐Sleeping ☐Sneezing ☐Squatting ☐Standing
☐Prolonged standing ☐Stress ☐Stretching ☐Taking a deep breath
☐Turning ☐ Twisting ☐Walking ☐Working ☐lying to sitting
☐sitting to standing ☐ lying to standing ☐ Sitting at Computer

Relieving Factors: What makes the problem better?

☐Anti-inflammatory ☐Bracing ☐Chiropractic Care ☐Elevation ☐Exercise ☐Heat ☐Ice
☐Massage ☐Movement ☐Pain Killers ☐Rest ☐Stretching ☐Walking

What activities of daily living are affected (or difficult) due to the problem?

☐Bathing ☐Caring for children ☐Cleaning ☐Climbing stairs ☐Cooking
☐Doing laundry ☐Dressing ☐Driving ☐Eating ☐Exercising
☐Sitting to standing ☐Grooming ☐Housework ☐Lying down ☐Lifting
☐Lying to sitting ☐Oral Care ☐Shopping ☐Sitting ☐Sleeping
☐Standing ☐Stretching ☐Transferring ☐Using technology ☐phone call
☐Walking ☐Watching TV ☐Working ☐Yard work ☐Social activities

On a scale of 1-10 (10 the worst pain you can imagine), what would you rate your pain TODAY

1 2 3 4 5 6 7 8 9 10

COMPLAINT 4 (CHECK ONLY 1 there is additional space for more complaints on next page)

☐Neck Pain ☐Headache ☐Migraine ☐ Upper/Mid Back Pain ☐Low Back Pain
☐Shoulder Pain ☐Knee Pain ☐Jaw Pain ☐Hip Pain
Pain or problem started on _____

Do you notice the pain during a certain time of day? ☐Morning ☐Afternoon ☐Evening ☐Night

Do you know what caused the problem?
☐Fall ☐Trauma ☐Accident ☐ Bending ☐Exercise ☐Housework ☐Lifting
☐Running ☐Working ☐Sports injury ☐Turning ☐Twisting ☐Sleeping wrong ☐Standing

Frequency: How often do you feel the pain?

☐ Constant ☐ Semi Constant ☐Comes and Goes ☐Other _____

Duration: How long does the pain last when you feel symptoms?

☐Constant ☐Frequent ☐Intermittent ☐Occasional ☐Infrequent ☐other _____

Onset: You have had this symptom over the past: Days, weeks, months or years?

☐Childhood ☐Adulthood ☐Year of_____ ☐Month of_____ ☐Exactly this date_____

Has the condition gotten better, worse or stayed the same since its onset?

☐Better ☐Worse ☐Stayed the Same

Quality: How would you describe the pain?

☐ Aching ☐Burning ☐Cramping ☐Deep ☐ Dull ☐Numb ☐Radiating ☐Sharp
☐Shooting ☐Sore ☐Stabbing ☐Stiff ☐Swelling ☐Tight ☐Tingling ☐Throbbing

Aggravating Factors: What makes the problem worse?

☐Nothing ☐Most Movements ☐Bending ☐Carrying things ☐Coughing ☐Driving
☐Eating ☐Exercise ☐down stairs ☐Heat ☐Housework ☐Ice
☐ Jogging ☐Lifting ☐Lying down ☐Massage ☐Pulling ☐Pushing
☐Running ☐Sitting ☐Sleeping ☐Sneezing ☐Squatting ☐Standing
☐Prolonged standing ☐Stress ☐Stretching ☐Taking a deep breath
☐Turning ☐ Twisting ☐Walking ☐Working ☐lying to sitting
☐sitting to standing ☐ lying to standing ☐ Sitting at Computer

Relieving Factors: What makes the problem better?

☐Anti-inflammatory ☐Bracing ☐Chiropractic Care ☐Elevation ☐Exercise ☐Heat ☐Ice
☐Massage ☐Movement ☐Pain Killers ☐Rest ☐Stretching ☐Walking

What activities of daily living are affected (or difficult) due to the problem?

☐Bathing ☐Caring for children ☐Cleaning ☐Climbing stairs ☐Cooking
☐Doing laundry ☐Dressing ☐Driving ☐Eating ☐Exercising
☐Sitting to standing ☐Grooming ☐Housework ☐Lying down ☐Lifting
☐Lying to sitting ☐Oral Care ☐Shopping ☐Sitting ☐Sleeping
☐Standing ☐Stretching ☐Transferring ☐Using technology ☐phone call
☐Walking ☐Watching TV ☐Working ☐Yard work ☐Social activities

On a scale of 1-10 (10 the worst pain you can imagine), what would you rate your pain TODAY

1 2 3 4 5 6 7 8 9 10